# Person-Centered Planning
# Real Goals for Real People



**PLANNING IS A WAY OF FIGURING OUT WHERE SOMEONE IS GOING AND WHAT KIND OF SUPPORTS THEY NEED TO GET THERE.**

CASE WORKER AND PROVIDER TRAINING 2013

# Person Centered Planning Regulatory Requirements



- Required planning process for adults receiving developmental services in Maine.
- Meets regulatory requirements, addresses resource allocation, communicates changes, and ensures consistency and accountability.
- Involves identifying and describing needs, goals and support services for person to live meaningful and self-directed life.

# Goals for Today



1. Review of person centered planning cornerstones
2. Discussion of caseworker  and provider role and responsibilities in the NEW PCP process
3. Learn about the NEW process from start to finish
4. Understand other participants roles

# Changes to The PCP Process



WHAT IS HAPPENING?

WHO IS THIS FOR?

WHY IS THIS HAPPENING?

WHEN IS THIS HAPPENING?

# What is Happening ?



- Individual and their families will direct the person centered planning process
- Case Managers will become Plan Coordinators for the NEW PCP process
- Provider Agencies will become the MaineCare Service planners (home, community and employment)
- PCP documentation will go into EIS as an assessment-then going forward it is re-versioned
- Goals will be refocused and personally defined

# Who is the New PCP process for?



- NEW PCP process must be used for all …
  - WAIVER section 21 and section 29 members
  - ADW members receiving developmental services case management
  - Wait list people receiving developmental services case management
  - Non Waiver people who only receive developmental services case management
  - Limited Benefits or Non Maine Care people who only receive developmental services case management (state cm only)
  - DD/MH  but receiving MH Case management (mh case worker) Kids getting waiver and Children's Case management

# Who is this NOT for?



- People who reside in …
- ICF/IID
  - Nursing
  - Group

  - Anyone who resides in a Nursing Facility

The Plans will be done by the facility they live in

# Why is this Happening ?



- The PCP change board has worked to streamline the PCP process and refocus it on the person
  - Will be entered into EIS as an assessment
  - Ease of access for OADS staff and agencies providing the services
  - Continuity of where items are tracked in the PCP
  - Goals will be in the voice of the person
- Center for Medicare and Medicaid Services

  Conflict Free Case Management- PCP
  - Need for informed choice and control by the person
  - No conflict between PCP and being paid for a service

# When is this Happening?



- Starting November 1st all state and adult community case managers will be the PCP coordinators as each individual plan transitions to the new process
  - need to account for Service Planning taking 45-60 days
  - Nov 1 2013 thru Feb 1 2014 each case manager must decide if there is time to begin the NEW process on PCP's due between due between Nov and Feb ( just this year ) if NOT then
    - The current process continues until the next cycle
  - ALL PLANS will have transitioned to NEW process by Feb 1, 2015

# Purpose of Planning & What to Remember



It's about…

-discovering peoples capacities

-creating a vision for a future

-developing the supports

-building community connections and relationships

-increasing valued roles

PRESENCE, CHOICE, COMPETENCE, RESPECT, COMMUNITY PARTICIPATION

# System Centered vs. Person Centered

by Dr. Beth Mount



As you plan remember the inherent tension between systems and people…

Acknowledge the tension and remember that people come first…

# Who is Involved in Planning?

**The person chooses who to invite, when to meet where to meet, who facilitates and what's on the agenda…**



## Who might be there?

- Person
- Guardian, family, friends
- Correspondent (OAB)
- Caseworker (MANDATORY)
- Agency staff
  - community, work and home
- Professionals involved – OT, PT, therapist, Dr
- Advocate must be notified may be invited

# Case Management is…



- A “key” or “linchpin” service
- Case managers act as an agent of the state human service system *and* an agent of the individual (first) and family
  - The “system” needs case management to keep the world running
  - The individual and family rely on case management to help them build and sustain lives

# Your Role in the PCP process…



**For the person and family**

- Engage in high quality, person-centered planning that keeps the *full* focus on the person
- Be the frontline for information and assistance
- Be a source of knowledgeable and thoughtful strategies to assist people with what is important to and important for them on behalf of…
- Be able to navigate community resources
- Be the front person for solving system problems of outcomes and quality on behalf of…

# Your Role in the PCP Process



**For the systems management**

- Case managers are the front line on coordinating, monitoring, quality compliance, outcomes and health & safety
- Upholding key Medicaid requirements
  - Informed choice and freedom of choice
  - Assuring rights

# What is New



- **Phase One: Process Coordination Part 1**
  - Case Worker acting as PCP Coordinator
    - With the person, determine when and where meeting will occur, who will be invited, begin developing agenda, determine facilitator
    - Confirm a location
    - Send out notices/invitations
    - Notify Advocate of meeting at least 2 weeks prior
    - Ensure Service Planning & Goal Descriptions are completed 30 days prior to plan meeting
    - Review Reportable events, IST, Safety Plan, Severely Intrusive Plan, if applicable
    - Begin working on the Face Sheet

# What is New



- **Phase Two: Service Planning**
  - The Service Provider (community, work, home) MUST meet individually with the person to develop Service Plans and Goals for each MaineCare Service.
  - The Case Manager MUST meet individually with the person to develop Case Management and Ancillary Services including goals
  - Service Planning should come from understanding the persons capacities, needs, desires, interests and goals for the next year.
  - 30 days prior to meeting based on the conversations with the person and support staff the Service Provider will complete the description in EIS for required MaineCare Services.

# What is New?



- **Phase Three: Process Coordination Part 2**
  - The Caseworker meets with the Person/Guardian to review Service & Goal Descriptions submitted and ensure they reflect the Person's informed choice of service provider, supports and meaningful goals.

    - Be sure EIS process and service description is complete.
    - Review Assessments/Forms for themes, conflicts, issues.
    - Review reportable events, IST's, etc
    - Work with Person/Guardian to identify any sensitive issues and make plan to address them.
    - Finalize meeting agenda with Person/Guardian that includes required discussions
    - Complete Profile section of Personal Plan Narrative
    - Document discussion and review of informed choice
    - Begin writing narrative of Summary of Process Coordination

# What is New?



## Phase Four: Personal Planning

The Focus Person and their team meet to review proposed plan as a whole, discuss how to coordinate goals across service areas, and plan how to enhance opportunities for community inclusion.

Providers Role:

Attend meeting to participate in coordination of goals across service areas. Review the MaineCare Service Descriptions submitted

Case Manager Role:

Facilitates meeting agenda (unless person chooses another facilitator), including items on Narrative.

Ensure any changes to Service & Goal Descriptions identified at the meeting are made in EIS.

# Effective Date



- The date upon which services described in the plan must start is fixed and in force for 365 calendar days. The effective plan date is the **same day each year**.
- For this first year the effective plan date is determined by the planning team at their upcoming planning meeting and then will be the same date each year thereafter. The new plan cannot be more than 365 days from the current plan.
- The planning meeting must be held no more than 45 calendar days prior to the effective plan date.
- The Plan Meeting date is **NOT** the same as the Effective Plan date.
- Waiver Reclass – plan cannot be older than 6 months from waiver date.
- NO MORE BRIDGE PLANS- MaineCare Rule change is happening now plans cannot be older than 365 days.

# What is New? -Timeline



- **Service Planning -** begins approx. 30 days prior to when the Service & Goal Descriptions must be completed in EIS
- **Completed Service & Goals Description in EIS (or to the case manager, when there is NO EIS access)–** occurs at least 30 business days prior to scheduled Personal Plan Meeting.
- **Personal Plan Meeting –** the final planning meeting must be no more than 45 calendar days prior to the Effective Plan Date
- **Effective Plan Date –** This is a FIXED month and day (does not change) from year to year. PCP Plan is complete** and approved by Case Manager.
- **Waiver Reclassification Date –** This is a FIXED month and day (does not change) from year to year. Complete** PCP must be received by the Resource Coordinator 30 calendar days prior to Reclass Date. The plan should be less than six (6) months old at the time of the member's eligibility determination or redetermination. If it is not, refer to the MaineCare Section 21 and Section 29 rules.

# What is New?
# Timelines



- ****Complete Plan means:**

  The Face Sheet, Personal Plan Narrative, Service Descriptions and Goal Descriptions are completed for each service and entered into EIS; and that all required signatures approving the plan have been obtained on the signature page. The PCP must have been reviewed and approved by the Case Manager

  **Another way of saying it:**

  The PCP must have been reviewed and approved by the Case Manager. Case Managers have 45 days between receiving the Service Description(s) and the Effective Plan date to hold the meeting, review, complete and approve the plan in EIS and obtain signatures of person and guardian(if applicable)

  - Case Manager notifies the agencies the plan is complete and sends person/guardian copy (anyone without EIS access)

# Changes to PCP Forms and Documentation



No longer use: Team Recommendation Form, Response Sheet/Essential Tool or Continuing Service Form, separate Service Proposal.

Moved: Consumer and Guardian Signature are on the Face Sheet, along with indicating continuing services. Attendance and date of Plan Meeting are now on Personal Plan Narrative.

New or Revised:

- Face Sheet
- Narrative
- Goal Descriptions
- Service Descriptions
  - Home Supports
  - Community Supports
  - Work/Employment Supports
  - Case Management
  - Ancillary Services

# Required Discussions, Manual, page 16



- Health & Safety (health risks, behavioral risks and personal safety)
- Employment (plan for and potential barrier(s) to)
- Guardianship (need, type and alternatives)
- Coordinating goals across service areas
- Communication (style and barriers to communication)
- Unmet Needs-(dental, housing etc.)

# What is the Same?



- Team Members
- Medical/Dental Monitor
- Critical Information Monitor
- Notifying Advocate ( changing mid October 2013)
- Sensitive Issues
- Personal Profile
- Assessing Consumer Satisfaction
- Sign off by the Person/Guardian and Case Manager
- Addendums (but not to extend the effective date)
- Pre/Post Meeting-for major service changes
- PCP reviews still determined by the team
- Needs/Desires/Unmet Needs – manual page 26 & 27
- Individual Support Team (IST), Safety Plans, Severely Intrusive Plans, Medical Add-ons and enhanced rates for shared living

# Where to track an Unmet Need?

## Manual, Page 27



- A need (not a desire) will be identified and treated as an “unmet need” when:

  A. It has not been met within the time frame set by the team, or

  B. Whenever the team has determined, at any point in the process, that a resource required to meet the need is not available.

  - Track unmet needs on the face sheet, personal plan narrative, develop an interim plan (goal sheet), write up in case management services and also Services and Supports assessment (cm responsibility)

# What is a Goal? Manual page 25



***An outcome the person wishes to achieve…***

and is:

- Written in plain language
- Observable- you can “see” it
- About what the person wants to do (important to)
- A balance between detail and open-endedness
- Gives meaning to the Person’s life

# THE FIVE ACCOMPLISHMENTS PROVIDE A GUIDE FOR THE DEVELOPMENT OF A PERSONAL VISION

By John O'Brien and Connie Lyle O'Brien

The five accomplishments provide a framework for assessing our ideas about the future. Increasing opportunity in these five areas of life is clearly the intended outcome of the Personal Futures Plan process.

**Will our ideas reinforce old patterns of isolation, rejection, powerlessness, and poor reputations?**

**Moving away from a past characterized by:**

- Isolation, seclusion, and separation by location, activities and schedule
- Rejection, loneliness, always on the outside, ignored
- Old stories, negative reputations, labels; negative self-fulfilling prophecies
- Limited voice, restriction, lack of representation, no power
- Unproductive, severely ignored, undeveloped; no resources, low expectations

**Will our choices lead to relationships, dignity, choice, real contribution, and inclusion in community life?**

Moving toward daily experiences which include:

- **COMMUNITY PRESENCE**: How can we increase the presence of a person in local community life?
- **COMMUNITY PARTICIPATION**: How can we expand and deepen people's relationships?
- **ENCOURAGING VALUED SOCIAL ROLES**: How can we enhance the reputation people have and increase the number of valued ways people can contribute?
- **PROMOTING CHOICE**: How can we help people have more control and choice in life?
- **SUPPORTING CONTRIBUTION**: How can we assist people to develop more competencies?

Adapted by PAL www.pal-ri.org from *Implementing Person-Centered Planning* by John O'Brien & Connie Lyle O'Brien, Inclusion Press:Toronto, 1998

# A Goal is NOT…



- A Service Description
- A “Hab Plan” or Plan of Care
- To measure percentages of success or number of trials
- Always an activity that relates to the services described

# Examples of Goals



John will explore his new neighborhood by visiting the places he can walk to (presence)

Bob will plan a BBQ and invite his family and friends to celebrate the 4th of July (participation in relationships)

Jane will discover opportunities for volunteering at the local library or Y day care (valued social role)

Kim will choose what she does for the upcoming holidays (increased autonomy)

Laura will increase her production at work to be eligible for a pay raise (increasing competencies)

# Service Planning & Goal writing

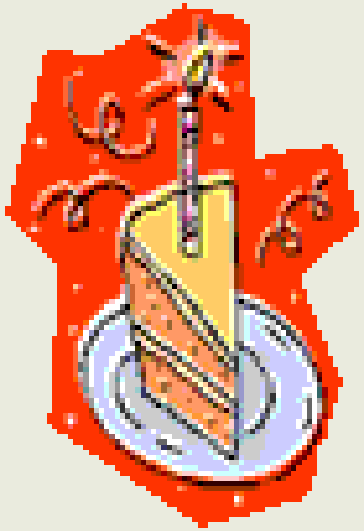


- Part of the planning process that is most essential to designing services that are person-centered.
- Service Planning takes place over a period of time
- Service Description indicates level and purpose of support.
  - Person might need support  with: personal hygiene, mobility, meal planning, safety skills – these more likely are service needs and not goals

- Goals differ from services
  - And may or may not be connected to a MaineCare Service
  - All goals should be captured even when they do NOT require a service to occur

# LUNCH BREAK





# The Forms of the PCP



**Case Worker has Responsibility for:**

- The Personal Plan Face Sheet -
- The Personal Plan Narrative
- Caseworker Service Description
- Ancillary Service Description

# The Forms of the PCP



**Service Provider has Responsibility for:**

- Home Supports Service Description
- Community Supports Service Description
- Work/Employment Supports Service Description
- Goal development
- Narratives for each service

30 Days prior to the Plan Meeting into EIS by the M/C Agency

# Practice MaineCare Service Planning



- Exercise: Read the story of Anne Brown
  - Community Supports- what services and what goals-review
  - Work Supports-what services and what goals-review
  - Home Supports-what services and what goals-review
  - Case Management Services- do service planning
  - Ancillary Services-do service planning

# CM - Meeting with the person/guardian and Reviewing the Service Descriptions (cm)



- In EIS Service Descriptions, can be printed to bring
- Meet with the person (and guardian) This is done without the agency present before the meeting
  - Discuss past year, what is important to and for the person
  - Discuss upcoming year and what they want and need to do
  - Review (and document) choice of services available to them through the Waivers and ensure they understand choice of who they are provided by
  - Cover required conversation, and any pre meeting issues, agenda, time, place, facilitation etc…
  - Discuss proposed Community, Home, Work Service Descriptions

# The Meeting



- Go over ground rules, time, housekeeping
- Facilitation and note taking- using the agenda
- Discuss required conversation-
  - Employment, guardianship, h & s, unmet needs, coordinate goals and services, communication
- Discuss Service Planning – agencies must attend and review ( community, work, home)
- What's been proposed and coordination- does anything need to change?
  - Goals the person wants to achieve-
  - OTHER discussions

# QA and how do you know it's working?



Case Managers and team members are asking-and need to document in the plan

- How was the planning process for you? What would you change and what did you like?
- How is the plan going? Are you getting the supports to do the things you want and need? How satisfied are you with what you are receiving?
- Are you accomplishing your goals?

# After the Meeting



- Finalize the Personal Plan Face Sheet (cm)
- Finalize the Personal Plan Narratives (cm)
- Finalize CM and Ancillary Service Descriptions (cm)
- Ensure Community, Work, Home Service Descriptions are accurate (agency and cm)
- Print a copy of the entire plan and gather required signatures (cm)
- Alert agencies when the plan is complete (cm)
- Provide copy of plan to person and guardian (cm)

# In Person Centered Planning Am I …



…assisting people to

- make and sustain connections, memberships and friendships?
- enhance their reputations?
- increase their active involvement in the life of communities?
- develop and invest their gifts and capacities?
- increase choice and control in their lives?

# Remember it’s all about the person



Thank you for being here!

Last QA?

- Fill out your evaluation and hand in and lastly…
- Remember it is one plan at a time…
- Refer to the manual for questions
- Lean on your Supervisors and T/A for support